Oklahoma Wisdom Teeth Center

PATIENT REGISTRATION FORM

(PLEASE PRINT)

NAME (first, mid, last) ____Goes by_______________________

DATE OF BIRTH_____/_____/_____ AGE______ SEX_______ S.S.# ________-- ______ -- _____________

HOME ADDRESS__________________________________City________________State________Zip__________

TELEPHONE home_______________________work_________________________cell_______________________

Is patient a full time student? _______ Attending: ______________________________Grade/year? _______________

Employer____Occupation__________________________

Personal Dentist______________________________________**Orthodontist**_______________________________

Emergency contact _______________________________ Relationship____________ Phone #________________

Single ( ) Widowed ( ) Married ( ) Name of spouse __________________________________# children _____

Spouse's Employer_______________________________ Spouse's occupation______________________________

Church/Religious preference____

Referred By: Dentist ( ) Friend ( ) Phone Book ( ) Insurance Co. ( ) Other ________________________

Have we had the privilege of treating your family members? If yes, who?________________________________

Insurance Information

Medical_______________________________________ Dental ____

Holders Name_________________________________ Holders Name ____________________________________

Holders DOB__________________________________ Holders DOB ______________________________________

Holders SS#___________________________________ Holders SS#____

Authorization to Release Information:

I authorize Oklahoma Wisdom Teeth Center to furnish information to my insurance carrier concerning my condition and/ or treatment.

X____ **Date**_____________

Assignment of Benefits:

I assign to Lloyd A Hudson, DDS, MD and/or Oklahoma Wisdom Teeth Center all payments for dental/medical services rendered to myself or any dependents.

X ____ **Date**_____________

Responsibility of Doctors Charges

I understand that I am responsible for any amount not covered by insurance.

X____ **Date**_____________

Primary Responsible Party (if other than patient)

Name____ Relationship to patient: Spouse Mother Father Other

Birth date _____/_____/_____ S.S. # ________-- ______ -- _________ Employer _________________ Wk #____________

HOME ADDRESS__________________________________City________________State________Zip__________

PATIENT HEALTH HISTORY

Your medical history is an **extremely important** part of your treatment plan. It helps to alert us to any potential problems that might interfere with your surgery. Please take the time to fill this out completely and accurately.

List **all prescription drugs** you are taking: ______________________________
____
____
____

List any **non-prescription drugs** you take (aspirin, herbal medicines, etc.)______________________________
____

List all **medications** to which you are **allergic** ______________________________
____

List the specific allergic reaction to the medication(s)______________________________

List any **contact allergies** including **latex** or other products______________________________

How is your **general health**? ( ) poor ( ) fair ( ) good ( ) excellent Current height [ ] Current weight [ ]

Please list any **operations** you have had, including date performed.
____

Describe any **difficulties** you have had with **anesthesia**______________________________

Do you use **tobacco**? ______ If so, what form and how much?______________________________

Do you drink **alcohol**? Please check one: ( ) none ( ) occasional ( ) moderate ( ) heavy

Are you under a **doctor's care**? YES ( ) NO ( ) If yes, who? ______________________________

What are you being treated for? ______________________________

WOMEN: Are you **pregnant, breastfeeding, or is there a chance you may be pregnant?**______________

WOMEN on birth control: I am informed and agree to use an additional form of birth control or abstain from sexual intercourse while taking antibiotics. **Patient Signature X**______________________________

Please review this list and check "Yes" or "No" to anything applicable.

Yes NO

( ) ( ) Heart disease/heart attack (**if yes give dates and treatment**) ______________________________
( ) ( ) Heart murmur
( ) ( ) Damaged/artificial heart valves
( ) ( ) Chest pain (**if yes, how often**?)______________
( ) ( ) Rheumatic fever
( ) ( ) High blood pressure
( ) ( ) Stroke (**if yes, when**)______________
( ) ( ) Asthma (if yes, do you have an inhaler?) _____
( ) ( ) Breathing problems/short of breath
( ) ( ) Hepatitis: A; B; C; Other, **Please Circle**
( ) ( ) TMJ or jaw muscle problems
( ) ( ) Joint replacement
( ) ( ) Fainting spells (when nervous or at the sight a of needle)
( ) ( ) Glaucoma
( ) ( ) Unusual bleeding
( ) ( ) Diabetes (**insulin or non-insulin** dependent/pill) **Please Circle**
( ) ( ) Seizure disorder (epilepsy)
( ) ( ) Cancer or tumor
( ) ( ) Radiation or Chemo (if yes for what and when) __________
( ) ( ) Depression/psychological disorder
( ) ( ) HIV
( ) ( ) Thyroid problems

Any medical or dental issues not covered above? ______________________________
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